L.D. 1196

Date: (Filing No. H-)

HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

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STATE OF MAINE

HOUSE OF REPRESENTATIVES

130TH LEGISLATURE

SECOND REGULAR SESSION

COMMITTEE AMENDMENT " " to H.P. 874, L.D. 1196, "An Act Regarding Targets for Health Plan Investments in Primary Care and Behavioral Health"

Amend the bill by striking out the title and substituting the following:

'An Act Regarding Reporting on Spending for Behavioral Health Care Services and To Clarify Requirements for Credentialing by Health Insurance Carriers'

Amend the bill by striking out everything after the enacting clause and inserting the following:

'PART A

Sec. A-1. 24-A MRSA §6903, sub-§1-A is enacted to read:

1-A. Behavioral health care. "Behavioral health care" means services to address mental health and substance use conditions.

Sec. A-2. 24-A MRSA §6951, sub-§13 is enacted to read:

13. Behavioral health care reporting. Beginning January 15, 2023 and annually thereafter, the forum shall submit to the Department of Health and Human Services and the joint standing committee of the Legislature having jurisdiction over health coverage and health insurance matters a report on behavioral health care spending using claims data from the Maine Health Data Organization and information on the methods used to reimburse behavioral health care providers requested annually from payors. As used in this subsection, "payor" has the same meaning as in Title 22, section 8702, subsection 8. The report must include:

A. Of their respective total medical expenditures, the percentage paid for behavioral health care by commercial insurers, the MaineCare program, Medicare, the organization that administers health insurance for state employees and the Maine Education Association benefits trust and the average percentage of total medical expenditures paid for behavioral health care across all payors;

B. The total behavioral health care-related nonclaims-based payments and associated member months;

C. The total payments associated with substance use disorder services that are redacted from the payor's claims data submissions to the Maine Health Data Organization as required under 42 Code of Federal Regulations, Part 2, the methods used to redact the substance use disorder claims, the specific code lists that are used for procedure codes, revenue codes and diagnosis codes, provider types and any other detail on the claim that is required to select the substance use disorder redacted claim; and

D. The methods used by commercial insurers, the MaineCare program, Medicare, the organization that administers health insurance for state employees and the Maine Education Association benefits trust to pay for behavioral health care.

Within 60 days of a request from the Maine Health Data Organization, a payor shall provide the supplemental datasets specific to payments for behavioral health care services necessary to provide the information required in paragraphs B and C. In its request to a payor, the organization shall specify the time period for which the data is requested and define the datasets requested to ensure uniformity in the data submitted by payors.

Sec. A-3. Maine Quality Forum to conduct health spending reporting study. The Maine Quality Forum, established in the Maine Revised Statutes, Title 24-A, section 6951, shall consult with other state and national agencies and organizations to determine the best practices for reporting spending on behavioral health care by insurers. For purposes of this section, "behavioral health care" means services to address mental health and substance use conditions.

PART B

Sec. B-1. 24-A MRSA §4303, sub-§2, ¶D, as amended by PL 2015, c. 84, §1, is further amended to read:

D. A carrier shall make credentialing decisions, including those granting or denying credentials, within 60 days of receipt of a completed credentialing application from a provider. ~~The time period for granting or denying credentials may be extended upon written notification from the carrier within 60 days following submission of a completed application stating that information contained in the application requires additional time for verification. All credentialing decisions must be made within 180 days of receipt of a completed application.~~ For the purposes of this paragraph, an application is completed if the application includes all of the information required by the uniform credentialing application used by carriers and providers in this State, such attachments to that application as required by the carrier at the time of application and all corrections required by the carrier. ~~A~~ Within 30 days of initial receipt of a credentialing application, a carrier shall review the entire application ~~before returning~~ and, if it is incomplete, shall return it to the provider for corrections with a comprehensive list of all corrections needed at the time the application is first returned to the provider. A carrier may not require that a provider have a home address within the State before accepting an application. A carrier that is unable to make a credentialing decision on a completed credentialing application within the 60-day period as required in this paragraph shall notify the bureau in writing prior to the expiration of the 60-day period on that application and request authorization for an

extension on that application. A carrier that requests an extension shall also submit to the bureau an explanation of the reasons why the credentialing decision on an application is taking longer than is permitted or, if the problem is not specific to a particular application, a written remediation plan to bring the carrier's credentialing practices in line with the 60-day limit in this paragraph.

Sec. B-2. Bureau of Insurance review. The Department of Professional and Financial Regulation, Bureau of Insurance shall review the requirements in Bureau of Insurance rule Chapter 850, Health Plan Accountability, related to the verification of information on credentialing applications from health care practitioners and determine whether amendments must be made to the rule's requirements in order to improve the ability of carriers to make a credentialing decision within the 60-day period in accordance with the Maine Revised Statutes, Title 24-A, section 4303, subsection 2, paragraph D without an impact on quality standards or accreditation standards. Notwithstanding Title 24-A, section 4309, any amendments to Bureau of Insurance rule Chapter 850 adopted following the review required by this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. B-3. Appropriations and allocations. The following appropriations and allocations are made.

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

Insurance - Bureau of 0092

Initiative: Provides funding for one Senior Insurance Examiner position and related All Other costs to examine insurer requests related to accreditation of health care providers.

OTHER SPECIAL REVENUE FUNDS	**2021-22**	**2022-23**
POSITIONS - LEGISLATIVE COUNT	0.000	1.000
Personal Services	$0	$121,132
All Other	$0	$10,803
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$131,935

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Amend the bill by relettering or renumbering any nonconsecutive Part letter or section number to read consecutively.

SUMMARY

This amendment replaces the bill.

Under current law, the Maine Quality Forum has been required to submit an annual report on primary care spending since 2020. Part A of the amendment requires the Maine Quality Forum to submit an annual report, beginning January 15, 2023, for behavioral health care spending based on claims data reported to the Maine Health Data Organization and information on methods of reimbursement reported by insurers.

Part B of the amendment requires carriers to make all credentialing decisions on a completed application within 60 days and requires an insurance carrier to notify a health care provider if an application is incomplete and needs correction within 30 days of initial receipt of an application. A carrier that is unable to make a credentialing decision on a

completed credentialing application within the 60-day period must notify the Department of Professional and Financial Regulation, Bureau of Insurance in writing prior to the expiration of the 60-day period on that application and request authorization for an extension on that application. A carrier that requests an extension must also submit to the bureau an explanation of the reasons why the credentialing decision on an application is taking longer than is permitted or, if the problem is not specific to a particular application, a written remediation plan to bring the carrier's credentialing practices in line with the 60-day limit.

Part B also requires the Bureau of Insurance to review the requirements in Bureau of Insurance rule Chapter 850, Health Plan Accountability, related to the verification of information on credentialing applications from health care practitioners and determine whether amendments must be made to the requirements for carriers to verify certain information on a credentialing application in order to improve the ability of carriers to make a credentialing decision within the 60-day period without an impact on quality standards or accreditation standards. It also adds an appropriations and allocations section.

FISCAL NOTE REQUIRED

(See attached)